

U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)



Issue Date: 19 June 2007

.....
In the Matter of:

S.G.,

Claimant,

v.

Case No. 2005-BLA-05161

**KING JAMES COAL CO./
KENTUCKY COAL PRODUCERS
SELF-INSURANCE FUND,**
Employer/Carrier, and

**DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,**
Party-In-Interest.

.....
Appearances:

John L. Grigsby, Esq. Appalachian Research and Defense Fund of Kentucky, Inc.,
Barboursville, KY
For Claimant

David Neeley, Esq., Neeley Law Office, P.S.C. Prestonsburg, KY
For Employer/Carrier

Donna E. Sonner, Esq., Office of the Solicitor, U.S. Department of Labor, Nashville, TN
For the Director

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter “the Act”) filed by Claimant S.G. (“Claimant”) on July 29, 2002. The instant claim is the second claim filed by Claimant. The putative responsible operator is King James Coal Company (“Employer”), which is insured through the Kentucky Coal

Producers Self-Insurance Fund (“Carrier.”) Although the hearing in this matter was held before the Honorable Richard E. Huddleston, it was assigned to the undersigned administrative law judge for disposition in light of Judge Huddleston’s retirement. No payments are being made by the Black Lung Disability Trust Fund.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also applicable, as this claim was filed after January 19, 2001.¹ 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor*, 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.² The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court’s ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

Claimant’s first claim was filed on July 28, 1997. (DX 1).³ That claim was denied by a claims examiner at the district director’s office on November 12, 1997 based upon Claimant’s failure to establish that he had pneumoconiosis, that the disease arose from his coal mine employment, or that he was totally disabled by the disease. *Id.* Claimant’s request for modification was denied by the district director on June 15, 1998 based upon Claimant’s failure to establish a mistake in a determination of fact or a change in conditions since the time of the previous denial. *Id.* When Claimant appealed, additional evidence was developed, and an informal conference was held on December 28, 1998. *Id.* At the conclusion of the conference, in a memorandum dated March 3, 1999, the district director determined that Employer (King James Coal Company) was primarily liable and Pond Creek Coal Company was secondarily liable, that the Claimant had established nine years and ten months of coal mine employment, and that the evidence did not establish a mistake in a finding of fact or a change in the Claimant’s condition. *Id.* The district director again found that the evidence did not establish any of the medical elements of entitlement and the claim was again denied. *Id.* The Claimant was advised that the district director’s determination would become the final determination of the Department of Labor if no rejection or appeal was filed within 30 days. *Id.* No further appeal was received.

Claimant filed the instant claim on July 29, 2002. (DX 3). An examination was conducted before Dr. Glen Baker on October 30, 2002. (DX 10). The district director issued a March 5, 2003 Schedule for the Submission of Additional Evidence, which indicated that

¹ Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

² Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

³ Director’s Exhibits, Claimant’s Exhibits, and Employer’s Exhibits are referenced as “DX”, “CX”, and “EX”, respectively, followed by the exhibit number. References to the hearing transcript appear as “Tr.” followed by the page number.

Claimant would not be entitled to benefits based on the initial evidence and that King James Coal Company, Inc. was the responsible operator. (DX 22). On a preliminary basis, the District Director's office concluded that the evidence indicated that Claimant worked as a coal miner for nine years and that Claimant has pneumoconiosis, but that Claimant's pneumoconiosis was not caused by exposure to coal mine dust, Claimant did not have a totally disabling respiratory or pulmonary impairment, and the totally disabling impairment was not caused at least in part by pneumoconiosis. *Id.* Despite the finding of pneumoconiosis, the Entitlement Analysis portion of the Schedule found that the Claimant had not demonstrated that any of the applicable conditions of entitlement had changed since the prior denial. *Id.* On August 7, 2003, a Proposed Decision and Order was issued by the District Director denying benefits on the same grounds and on the additional grounds that the evidence did not show that the Claimant had pneumoconiosis. (DX 27). Claimant requested a hearing before the Office of Administrative Law Judges. (DX 25). The case was initially transmitted for a hearing on November 19, 2003, but it was remanded by Administrative Law Judge Daniel J. Roketenetz on June 7, 2004 for the conduct of a complete medical examination in compliance with section 725.241, because Dr. Baker had failed to credibly address all the conditions of entitlement in his report. (DX 32). After Dr. Baker was asked for, and provided, a report (dated August 17, 2004) providing additional information (DX 33), the case was again transmitted to the Office of Administrative Law Judges on November 3, 2004 for a hearing. (DX 34).

A formal hearing in the above-captioned matter was held on February 2, 2006 in London, Kentucky before Judge Huddleston. At the hearing, Director's Exhibits 1 through 36 ("DX 1" through "DX 36") were admitted into evidence. (Tr. 5-9). The Director's summary of evidence was admitted as DX 37. (Tr. 12). Claimant's Exhibits 1 and 2 ("CX 1" and "CX 2") and Employer's Exhibits 1 through 3 ("EX 1 through "EX 3") were also admitted. (Tr. at 14-17). Claimant was the only witness to testify. At the conclusion of the proceedings, the record closed but the parties were given 60 days to submit briefs. Claimant's brief was submitted on April 3, 2006 and Employer's brief was submitted on March 16, 2006.

By Order of May 2, 2006, the parties were advised that the case would be reassigned because of Judge Huddleston's retirement and asked whether they would prefer to have a new hearing or a decision on the present record. By a notice filed on May 8, 2006, Claimant, through counsel, advised that he would prefer a decision on the present record. By letter of May 8, 2006, filed on May 11, 2006, counsel for Employer advised of no objection to reassignment and Employer's concurrence with Claimant's preference for a hearing on the record. Counsel for the Director also concurred, by letter filed on May 15, 2006. The case was returned to the docket for reassignment on June 6, 2006 and, thereafter, as assigned to the undersigned administrative law judge.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

The issues before me are the timeliness of the claim, length of coal mine employment, the existence of pneumoconiosis, its causal relationship with coal mine employment, total disability, causation of total disability, and the threshold issue of subsequent claims. (Tr. 9-12, 17; DX 34).

At the hearing, the Employer withdrew issues number 2 (Miner), 3 (Post 1969 Employment), 10 (Dependency of 1 dependent), 12 (Responsible Operator), 13 (Insurance), and issue 18(A) as it relates to responsible operator. (Tr. 9-11). Counsel for the Director indicated that issue 14 (Subsequent Claims under 20 C.F.R. §725.309) was also contested by the Director (Tr. 11) and the list of issues is amended to so reflect. **SO ORDERED.** Additional issues were listed under issue 18 (B) and (C) (Other Issues) primarily for appellate purposes. (Tr. 11-12).

At the hearing, the Director and the Employer offered to stipulate to nine years and ten months of coal mine employment, and Claimant initially offered to stipulate to ten years but withdrew the offer based upon Judge Huddleston's indication that it was in his best interest to establish as much coal mine employment as possible. (Tr. 9-10). Claimant has alleged 16 or 17 years of coal mine employment. (Tr. 10). Length of coal mine employment remains an issue.⁴

In the Brief on Behalf of Employer, filed on March 24, 2006, at page 5, footnote 4, the Employer withdrew the issue as to whether this subsequent claim was timely filed.

Medical Evidence

The newly submitted medical evidence in this case is listed below.

New interpretations of chest X-rays taken between 1997 and 2002, all but one of which (the July 29, 2002 reading, taken during a hospitalization) utilize the ILO system and are in compliance with the regulatory standards, are summarized below.⁵ By agreement of the parties, an interpretation by Dr. Baker that was present in the prior claim is also being considered along with this evidence. (Tr. 5-8). Although Dr. Baker's reading is not "new," it is worth noting that Dr. Halbert's, while technically "new," is similar to the reading he made of the same x-ray on September 22, 1997, in connection with the previous claim (although he noted a probable small calcified granuloma in the right upper lobe on the previous x-ray reading, DX 1).

Exhibit No.	Date of X-ray/ Reading	Physician/ Qualifications	Interpretations
DX 1 (Claimant Initial)	08/01/1997/ same	G. Baker B-reader	Pneumoconiosis 1/0, p/p, upper four zones; qualify 1.
DX 12 (Employer Initial)	08/01/1997/ 10/28/2002	D. Halbert B-reader, BCR	No opacities consistent with pneumoconiosis; "fr" fractures; quality 2 (right CPL clipped).
DX 15 (Claimant Initial)	07/29/2002/ same	J. Singh	Hospital report; not ILO form. 1. Stable. COPD. Aortic atherosclerosis. 2. No pneumonia, cardiomegaly or CHF.

⁴ The transmittal form CM-1025 does not reflect that length of coal mine employment was contested by the Director but that listing is apparently in error. (DX 34).

⁵ As used herein, "BCR" refers to a board-certified radiologist and "B-reader" refers to a physician certified by NIOSH to read x-rays. A list of B-readers appears at www.oalj.dol.gov (NIOSH Certified B-Reader List).

Exhibit No.	Date of X-ray/ Reading	Physician/ Qualifications	Interpretations
DX 10 (DOL exam)	10/30/2002/ same	G. Baker B-Reader	Pneumoconiosis 1/0, p/s, lower 5 zones; "ca"; quality 2 (CP angles, contrast).
DX 11 (DOL)	10/30/2002/ 12/03/2002	P. Barrett BCR & B- Reader	Quality only; quality 2 (pos [illegible]).
EX 1 (Employer Rebuttal)	10/30/2002/ 10/10/2003	D. Halbert B-Reader, BCR	Negative for pneumoconiosis; quality 2 (CPL's cl.)
DX 13 (Employer Initial)	11/05/2002/ same	B. Westerfield B-Reader	No opacities consistent with pneumoconiosis; "fr" old rib fracture on right; granulomas; quality 1.

Pulmonary function tests taken on September 19, 2002 (DX 15) (Brown, Claimant's Initial); October 30, 2002 (DX 10) (DOL Examination); and November 5, 2002 (DX 13, 16) (Westerfield, Employer's Initial) produced the following results:

Exhibit No.	Date/ Physician	Age/Height	FEV1 pre and post bronchodilator	FVC pre and post bronchodilator	MVV pre and post bronchodilator	FEV1/FVC pre and post bronchodilator
DX 15	09/19/2002 T. Brown	59 71 inches	1.89 (pre) 1.85 (post)	3.76 (pre) 3.55 (post)	62 (pre) 70 (post)	50% (pre) 52% (post)
DX 10	10/30/2002 G. Baker	59 71 inches	2.22 (pre)	4.61 (pre)	None	48 % (pre)
DX 13	11/05/2002 Westerfield	59 71 inches	2.25 (pre) 2.26 (post)	4.41 (pre) 4.79 (post)	79 (pre) 81 (post)	51% (pre) 47% (post)

Under subparagraph (i) of section 718.204(b)(2), total disability is established if the FEV1 value is equal to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if in addition, the tests reveal qualifying FVC or MVV values under the tables, or an FEV1/FVC ratio of less than 55%. Only the September 19, 2002 results are qualifying for total disability under the federal regulations, based upon qualifying FEV1, MVV, and FEV1/FVC ratio, both pre- and post-bronchodilator.

Arterial blood gases were taken on September 19, 2002 (DX 15) (Brown, Claimant's Initial); October 30, 2002 (DX 10) (DOL Examination); and November 5, 2002 (DX 13) (Westerfield, Employer's Initial). The ABGs produced the following values, all of which were taken at rest, and none of which were qualifying under Part 718, Appendix C:

Exhibit No.	Date	Physician	pCO2	pO2	Qualifying?
DX 15	09/19/2002	T. Brown	39.3 (rest)	80.0 (rest)	No
DX 10	10/30/2002	G. Baker	39.0 (rest)	69.0 (rest)	No
EX 13	11/05/2002	Westerfield	40.0 (rest)	75.0 (rest)	No

Medical opinions were rendered by four physicians: (1) Dr. Tammy Brown, Claimant's treating physician (DX 14, DX 15, CX 1) (Claimant's Initial); (2) Dr. Glen Baker, the DOL examiner (DX 10, 33) (DOL Examination); (3) Dr. Byron T. Westerfield, (DX 13) (Employer's Initial); and Dr. Bruce Broudy (EX 2) (Employer's Initial). Dr. Westerfield also had his deposition taken. (DX 16).

(1) Dr. Tammy Brown, Claimant's treating physician, prepared two statements, dated September 9, 2002 (DX 15) and March 13, 2003 (DX 14),⁶ and filled out a questionnaire, dated April 12, 2003 (CX 1).

In her March 13, 2003 report, Dr. Brown stated that she had been Claimant's local family physician for five years and that Claimant had been diagnosed with Black Lung disease; she also stated that his chest x-rays and pulmonary function tests were diagnostic of emphysema and, by history, related to silicosis. Further, she stated that he had chronic dyspnea, air-trapping, and cough which disabled him from employment, and she noted that his shortness of breath worsened with exertion. (DX 14).

In response to a questionnaire submitted by Claimant's counsel, Dr. Brown stated that Claimant had been her patient from January 1998 through April 2003, and that she had been treating him for black lung, his symptoms being shortness of breath, cough, wheezing, and recurrent bouts of acute bronchitis. Dr. Brown further indicated that she believed that Claimant has chronic pulmonary disease related to his 18 years of employment in the coal mines, based upon an abnormal chest x-ray that revealed emphysematous lungs and his prolonged (18 year) exposure to coal dust. She opined that Claimant was unable to perform the work of a coal miner due to exertional dyspnea. In support, she stated:

Pt. has recurrent bouts of bronchitis & pleuritic chest pain & he has had observed dyspnea when in the office walking from the waiting room to the exam room.

She further opined that Claimant's exposure to coal dust was "one major cause of his respiratory symptoms." (CX 1).

(2) Dr. Glen Baker performed the DOL pulmonary examination on Claimant on October 30, 2002, and he prepared a form report. (DX 10). In response to a remand from the Office of Administrative Law Judges, he provided a supplemental report dated August 17, 2004. (DX 33).

In his October 30, 2002 report, Dr. Baker took a history, performed a physical examination, and reviewed test results. He noted that Claimant was still smoking and had smoked for 25 years at a rate of 1/2 pack per day.⁷ He accepted the Claimant's coal mine employment history form and statement that he worked 16 years underground. On examination,

⁶ The March 13, 2003 report and April 12, 2003 questionnaire by Dr. Brown were designated by Claimant as his two reports. The third (September 20, 2002) report adds additional details concerning Dr. Brown's treatment of Claimant and is not in the nature of a medical opinion. Thus, the evidentiary limitations have not been exceeded.

⁷ At the time of Claimant's August 1, 1997 examination, he told Dr. Baker he began smoking in 1963, and the amount smoked was "1 PPD now, 1½ + in past." (DX 1).

he noted “soft wheezes” when the Claimant lay supine. Dr. Baker listed the following cardiopulmonary diagnoses and bases therefor:

1. Coal Workers’ Pneumoconiosis 1/0: abnormal chest x-ray and coal dust exposure
2. COPD with mild obstructive defect: PFTS
3. Hypoxemia: PO₂
4. Chronic bronchitis: history of cough, sputum production and wheezing
5. chest pain by history, ? chest wall

(DX 10). He attributed the first condition to coal mine dust exposure and the second, third, and fourth conditions to “coal mine dust exposure/cigarette smoking”; for the fifth condition, he stated “? etiology.” In the section of the form related to Impairment, he characterized the impairment as “mild with decreased FEV₁, chronic bronchitis, decreased PO₂ and Coal Workers’ Pneumoconiosis 1/0,” and he stated that the cardiopulmonary diagnoses contributed to the impairment “fully.” Under Non-Cardiopulmonary Diagnoses, he listed degenerative joint disease and arteriosclerotic obliterans. (DX 10). In a supplemental form, he indicated (by checking the appropriate box) that the Claimant had an occupational lung disease caused by his coal mine employment, that he had a mild impairment, and that he lacked the respiratory capacity to perform the work of a coal miner or comparable work in a dust free environment. (DX 10).

When asked for additional information in an August 2, 2004 request from a Senior Claims Examiner, Dr. Baker issued a supplemental report of August 17, 2004, in which he confirmed his findings on the bases stated and noted that the presence of x-ray changes consistent with coal workers pneumoconiosis and a history of occupational exposure of at least 10 years was “usually felt to be presumptive evidence in the absence of other causes that the changes are due to coal mine employment and coal dust exposure.” He also stated the following:

So in summary, he does have COPD, chronic bronchitis and arterial hypoxemia, which can be contributed to, to some extent by his coal dust exposure. If he only had 9 years of coal dust exposure and smoked 25 years, the coal dust exposure would be a minimal, and perhaps, not a significant contribution to his conditions. If he indeed had 16 years, then it would probably be significant and therefore be a cause of the miner’s condition. He does have a mild impairment. It is related primary to the obstructive airway disease and chronic bronchitis, as well as his resting arterial hypoxemia. These in turn can be related to pneumoconiosis as his coal dust exposure may have contributed to some extent in the causation of these problems.

(DX 33).

Of note, Dr. Baker also examined the Claimant (on August 1, 1997) in connection with his previous claim. (DX 1).

(3) Dr. Byron T. Westerfield, a board-certified pulmonologist⁸ and B-reader, examined the Claimant for the Employer on November 5, 2002. In the course of the examination, he

⁸ As used herein, a “board-certified pulmonologist”, is a physician who is board-certified in internal medicine and the subspecialty of pulmonary diseases.

performed a physical examination, took a history, and conducted testing. He noted that the Claimant was smoking one half pack of cigarettes daily, having smoked since his early 20's up to two packs of cigarettes per day, amounting to a 30- to 50-pack smoking history. Dr. Westerfield reached the following Impression:

1. History of exposure to coal dust.
2. Chronic obstructive lung disease which appears to be chronic bronchitis by history.
3. Cigarette smoking.
4. History of arthritis.

(DX 13).

At his April 18, 2003 deposition, Dr. Westerfield explained his conclusions further. (DX 16). Dr. Westerfield indicated that, in addition to the testing and x-rays taken at the time of his November 5, 2002 examination, he had reviewed additional x-rays of August 1, 1997 and October 16, 1997. *Id.* at 5-6. He described Claimant's respiratory symptoms of shortness of breath with exertional activities, bronchitis episodes, and daily productive cough, indicating a clinical diagnosis of chronic bronchitis. *Id.* He described Claimant's smoking history of 30- to 50- pack years as "truly dangerous," and he assumed a 20-year underground coal mining history, extending until 1985, which included operating a loading machine and a cutting machine. *Id.* at 7. When asked about his interpretation of the November 5, 2002 x-ray, which he found to be negative for pneumoconiosis, he testified as follows:

A. It is not completely negative. There are scattered granulomas. Granulomas are little scars in the lung and are usually seen with old histoplasmosis, which is a fungal infection, or tuberculosis.

Q. Is there any way to differentiate between what would be a granuloma as opposed to what would be a fibrotic change due to the inhalation of coal-mine dust?

A. Granulomas are rounded in size and they contain calcium. They generally are larger than pneumoconiotic nodules. Pneumoconiotic nodules can be as small as a millimeter and a half in size. Granulomas are closer to five millimeters to a centimeter in size and do contain calcium.

Q. How does the calcium show up on the x-ray?

A. Calcium is much denser. It's the density of the bone, so it's very white on the x-ray.

Id. at 9-10. He went on to state that pneumoconiosis nodules did not contain calcium and the two types of changes were easily distinguishable. *Id.*

With respect to the pulmonary function studies, Dr. Westerfield noted that the FVC was normal and the FEV1 was not, reflecting a moderate obstructive pulmonary impairment, which

was not consistent with pneumoconiosis.⁹ In this regard, he stated that pneumoconiosis causes a restrictive lung disease pattern on pulmonary function studies, which would be reflected by a reduction in the FVC not found here. He attributed the impairment to cigarette smoking because it “is the number-one cause of chronic obstructive pulmonary disease,” particularly when emphysema was present. He explained that cigarette smoking created two different processes, both of which Claimant has: emphysema (resulting from destruction in the lung parenchyma and collapse of the small airways) and chronic bronchitis (an airways disease resulting in hypertrophied bronchial tubes, increased mucous production, and narrowing of the bronchial tubes). *Id.* at 11-15. He discounted coal mine employment as a cause of the impairment because Claimant quit coal mine employment in 1985 and the respiratory symptoms did not show up until a few years ago.¹⁰ *Id.* at 21-22, 25.

He also noted that the arterial blood gases were normal. *Id.* at 15.

Dr. Westerfield characterized the impairment due to chronic obstructive pulmonary disease as “AMA Class II, 25 percent.” *Id.* at 21. He opined that the Claimant “could return to coal mining at a level of operating equipment” but that he “could not do arduous or heavy work” due to his reduced lung function on exertion *Id.* at 23.

Finally, Dr. Westerfield opined that the Claimant “has no medical condition that was caused, contributed to or aggravated by his coal-dust exposure.” *Id.* at 22.

In connection with Claimant’s previous claim, Dr. Westerfield also examined Claimant for the Employer on October 16, 1997 and expressed an opinion in multiple reports. (DX 1).

(4) Dr. Bruce Broudy, a board-certified pulmonologist and B-reader, conducted a medical record and medical opinion review and answered specific questions in a report of November 4, 2005. (EX 2)

In his November 4, 2005 report, Dr. Broudy opined that the medical evidence was not strong enough to support a diagnosis of coal worker’s pneumoconiosis, inasmuch as only one x-ray interpretation was positive.¹¹ When asked about legal pneumoconiosis, Dr. Broudy indicated that the records did not reflect that Claimant had a pulmonary disease that was caused, contributed to, or aggravated by coal dust exposure in coal mining. He also stated:

In my opinion, the record does not indicate that the miner has any chronic disease of the lung which has been materially affected by pneumoconiosis or the inhalation of coal mine dust. He has typical chronic obstructive airways disease due to cigarette smoking and there is no evidence that any lung impairment was related to coal dust exposure. When coal dust exposure causes impairment of this

⁹ Dr. Westerfield’s opinion may be hostile to the regulations, which acknowledge that obstructive pulmonary disease can be caused by coal mine dust exposure. See 20 C.F.R. § 718.201(a)(2).

¹⁰ Dr. Westerfield’s opinion is arguably contrary to the revised regulations, which recognize that pneumoconiosis is a latent and progressive disease which may first become detectable after cessation of coal mine dust exposure. See 20 C.F.R. § 718.201(c).

¹¹ Dr. Broudy considered all of the interpretations of the 2002 x-rays (including Dr. Baker’s positive interpretation) but he only considered Dr. Halbert’s interpretation of the August 1, 1997 x-ray (and not Dr. Baker’s).

severity, it is usually a restrictive type of impairment and usually there is significant radiographic evidence of pneumoconiosis.

(EX 2). Dr. Broudy opined that the Claimant did have pulmonary disease and dysfunction which was the result of chronic bronchitis and pulmonary emphysema from cigarette smoking.

Dr. Broudy also examined the Claimant for the Employer (on August 18, 1998) in connection with his previous claim. (DX 1).

Additional medical evidence is of record as part of the Claimant's initial claim. (DX 1).

Background and Employment History

Claimant was the only witness to testify at the hearing. He was born in 1942 and was 63 years old at the time of the hearing. (Tr. 18).

Claimant testified that he began working as a coal miner in 1960 for coal companies operated by his father and uncle, where he worked on and off until 1963. (Tr. 19, 20). He explained that while he worked full time (eight to twelve hours per day, six days per week) when he worked, the truck mines would close during the winter months, and he estimated he worked seven to eight months per year. (Tr. 19-20). His work entailed loading coal by hand, helping with the drill and blasting, and running an electric three-wheel tractor. (Tr. 21). Most of the time, he was paid by cash or personal check, and no Social Security was taken out. (Tr. 21). The mine where he worked in 1960 was in West Virginia and the mine where he later worked was located in Pike County, Kentucky. (Tr. 22). Claimant dropped out of school about halfway through his senior year, at age 18 or 19, to work. (Tr. 23).

Claimant's next mining job was in 1970, when he worked for Pond Creek Coal Company at Elkhorn Creek. (Tr. 23). His work included helping to shoot coal or coal preparation, as well as blasting, which involved using a hand-held drill and then loading the holes with powder, cap, and fuse. (Tr. 24). He only did the blasting work for two years. (Tr. 24). At that job, he worked 40 or more hours per week, and they were able to work in the winter because the roads were maintained. (Tr. 24). Claimant continued working for Pond Creek until 1981 or 1982, when King James was formed. (Tr. 25). His work at King James was for a year and one half or two years, and he stopped working for King James in approximately 1985. (Tr. 25). Although the Social Security records may have listed his employment in '72, '73, '74, '75, and '77 as self-employment, he was actually employed by Pond Creek during that period, as he was actually an owner starting in 1973, and he worked as a foreman. (Tr. 25). As a foreman, he did whatever needed to be done and filled in for people who missed work. (Tr. 26). When he worked for King James, he did essentially the same thing, as a working foreman or running the cutting machine. (Tr. 26-27). He did not do any mining after leaving King James. (Tr. 27).

Claimant estimated that he worked a total of twelve to fourteen years in coal mining. (Tr. 27). His work involved lifting as much as 75 pounds, when he was loading coal or moving a rock fall. (Tr. 28). Every three to five months, he would have to change tractor batteries that weighed close to 300 pounds, which involved two men lifting one of the batteries. (Tr. 28). His

work involved walking, squatting, and crawling. (Tr. 28). The lowest coal he worked in was 36 inches high. (Tr. 28). Claimant testified:

All of my time inside was pretty well spent near the face of the coal, except for when I had to make runs through the return, make pre-shift exam.

(Tr. 29). He further testified that all of his jobs were dusty, and that he only used a mask when he was spreading or scattering rock dust. (Tr. 29). Most of his coal mine employment was in Kentucky. (Tr. 39).

Claimant testified that he stopped mining because he was having health problems, specifically "foot, leg, back problems," as well as breathing problems. (Tr. 31). He explained: "Well, just hard to breath, coughing a lot, and sputum, coughing up phlegm, and just smothering. (Tr. 31). However, on cross examination, he admitted that he left mining as a matter of economics. (Tr. 46).

For his breathing, Claimant uses Primatene Mist and is on Allegra-D. (Tr. 31). Claimant can walk about 100 yards before becoming short of breath but he has difficulty climbing stairs or walking uphill, and he has trouble breathing at night. (Tr. 31-32). His breathing worsened in the five years preceding the hearing and he did not believe he was capable of performing his coal mine jobs based upon his breathing alone. (Tr. 35-36).

Claimant stopped working entirely in 1997 because he "had to quit." (Tr. 34). He was hospitalized due to an infected foot, that was infected due to a disorder of the veins in his foot that resulted in the blood pooling there. (Tr. 34). His foot had been previously injured while mining. (Tr. 34). Upon his discharge from the hospital, he applied for Social Security and he started getting it in July or August of 1998. (Tr. 34).

Dr. Tammy Brown is Claimant's treating physician, and she has been treating him for the last seven or eight years (prior to the hearing). (Tr. 32). She treats him for his back and foot, as well as for his breathing problems and keeping his sugar under control. (Tr. 32). Dr. Baker has never been his treating physician but he selected Dr. Baker for his black lung examination. (Tr. 33). Claimant testified that he did as well as he could on the breathing tests that Dr. Baker administered. (Tr. 33).

Claimant admitted that he had been a smoker for most of his adult life, but he had recently (December 2005) given up the habit. (Tr. 33, 37). Before he quit, he was down to two to three cigarettes daily. (Tr. 33-34). Although at one time he smoked one and one half packs per day, he stopped doing so in 1973 or 1974, when regulations prevented cigarettes or lighters to be taken underground. (Tr. 37). In the 2002 to 2004 period, he was not smoking more than one pack per day. (Tr. 38). Assuming that Claimant began smoking at age 21, in 1963, as he told Dr. Baker in 1997 (DX 1), his smoking history may be estimated as 45-pack years (based upon one and one half pack daily from 1963 to 1973 and one pack daily from 1973 to 2003.)

Discussion

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 21 BLR 1-47, BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), *citing* 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each “submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports.” *Id.*, *citing* 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit “no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by” the opposing party “and by the Director pursuant to §725.406.” *Id.*, *citing* 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit “an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing,” and, where a medical report is undermined by rebuttal evidence, “an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.” *Id.* “Notwithstanding the limitations” of section 725.414(a)(2),(a)(3), “any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence.” *Id.*, *citing* 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 “shall not be admitted into the hearing record in the absence of good cause.” *Id.*, *citing* 20 C.F.R. §725.456(b)(1). The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey*, *supra*. First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered “other medical evidence.” *Dempsey* at 5; see 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). However, in *Webber v. Peabody Coal Co.*, 23 B.L.R. 1-___, BRB No. 05-0335 BLA (Jan. 27, 2006) (en banc), the Board changed the position that it took in *Dempsey* with respect to CT scan evidence and adopted the Director's position that “the use of singular phrasing in 20 C.F.R. § 718.107” requires “only one reading or interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence.” Second, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. Third, the Board held that state claim medical evidence is properly excluded if it contains testing that exceeds the evidentiary limitations at § 725.414. In so holding, the Board noted that such

records did not fall within the exceptions for hospitalization or treatment records or for evidence from prior federal black lung claims. *Dempsey* at 5. Fourth, on the issue of good cause for waiver of the regulations, the Board noted that a finding of relevancy would not constitute good cause and therefore records in excess of the limitations offered on that basis, and on the basis that the excluded evidence would be “helpful and necessary” for the reviewing physicians to make an accurate diagnosis, were properly excluded. *Dempsey* at 6. Finally, the Board stated that inasmuch as the regulations do not specify what is to be done with a medical report that references inadmissible evidence, it was not an abuse of discretion to decline to consider an opinion that was “inextricably intertwined” with excluded evidence. *Dempsey* at 9. Referencing *Peabody Coal Co. v. Durbin*, 165 F.3d 1126, 21 B.L.R. 2-538 (7th Cir. 1999), the Board acknowledged that it was adopting a rule contrary to the common law rule allowing inadmissible evidence to be considered by a medical expert, because “[t]he revised regulations limit the scope of expert testimony to admissible evidence.” *Dempsey* at 9-11.

In *Brasher v. Pleasant View Mining, Inc.*, BRB No. 05-0570 BLA (BRB April 28, 2006), slip op. at 6, the Board noted that, where a physician’s reports constitute two separate written assessments of the miner’s pulmonary condition at two different times, an administrative law judge may properly decline to consider them as a single medical report under the evidentiary limitations.

The evidence in the instant claim is in compliance with the evidentiary limitations, except for the fact that some of the medical opinions, particularly that of Dr. Westerfield as expressed at his deposition, discuss inadmissible evidence. In reviewing the medical evidence in this case, I will strike the inadmissible references and will consider the remainder of the opinions to the extent not inextricably intertwined with the inadmissible evidence.¹²

The documents from the prior claim were admitted into evidence as DX 1. Section 725.309(d)(1) provides that “any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.” Additionally, in *Church v. Kentland-Elkhorn Coal Corp.*, BRB Nos. 04-0617 BLA and 04-0617 BLA (Apr. 8, 2005)(unpub.), the Board stated that “as noted by the Director, when a living miner files a subsequent claim, all evidence from the first miner’s claim is specifically made part of the record.” Therefore, all evidence relating to the prior claim is admissible.

Length of Coal Mine Employment

For the reasons set forth below, I find that the Claimant has established 11 years of coal mine employment. At the informal conference for the first claim, the district director found that the Claimant had established nine years and ten months of coal mine employment based upon earnings reflected in the Social Security records and, at the hearing, both the Employer and the Director agreed to that amount. (DX 1; Tr. 9-10). Although in connection with this claim, the

¹² In saying that I will “strike” the inadmissible references, I do not mean that I will actually go through the evidence and use a marker to cross out the inadmissible portions. Rather, I will not take the inadmissible evidence (or any other evidence solely based upon it or inextricably intertwined with it) into account when evaluating the evidence.

district director only found nine years of coal mine employment during the period from January 1, 1971 to February 1, 1985, the district director has stated no rationale for the changed calculation (DX 23) and I accept the calculations from the informal conference. At neither time did the district director take into consideration Claimant's alleged employment from 1960 to 1963 for his father and uncle, as reflected by his Employment History form (DX 4) and his testimony. While credible to a point, the Claimant's testimony concerning the dates he worked for his family in West Virginia and Kentucky is inconsistent with the Social Security records, which reflect sporadic employment with other entities, including employers in Illinois and Florida, during this period. Further, these records show he was continuously employed by Anchor Metal Finishing, Inc. in Franklin Park, Illinois, beginning in the quarter from July to September of 1962 and extending into 1964. Thus, while I accept the fact that Claimant worked in coal mine employment in the early 1960's, I cannot credit him with the entire amount of time that he claimed to have been working for his father and uncle. Instead of the seven to eight months yearly estimated by Claimant, I find that six months yearly is a better estimate, and I find no basis for crediting him with employment after September 1962. Allowing for the period that he was employed elsewhere, I find that he worked for one year and three months in coal mine employment in the early 1960's (based upon six months per year during the 2½ year period from March 1960 until September 1962.) Based upon the Social Security earnings records, the Employment History form, and Claimant's testimony, I find that Claimant has established 11 years of coal mine employment extending over a cumulative 16-year period (between March 1960 and September 1962 and between January 1971 and July 1984).

Subsequent Claims Analysis

The instant case is a subsequent claim, because it was filed more than one year after the prior denial of benefits in March 1999. See §725.309(d). Previously, such a claim would be denied based upon the prior denial unless the Claimant could establish a material change in conditions. See 20 C.F.R. §725.309(d). The Sixth Circuit Court of Appeals held that to find that a material change in condition has occurred, between an earlier denial of a claim under the Act and a subsequent claim, the administrative law judge must consider all of the new evidence, favorable and unfavorable, and determine whether the miner employee has proven at least one of the elements of entitlement previously adjudicated against him. *Kentland Elkhorn Coal Corp. v. Hall*, 287 F. 3d 555, 559 (6th Cir. 2002); citing *Sharondale Corp. v. Ross*, 42 F.3d 993, 997-98 (6th Cir. 1994). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. *Id.* Then the administrative law judge must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits. *Id.*

The amended regulations have replaced the material-change-in-conditions standard with the following standard:

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see §725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. **A subsequent claim** shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part,

except that the claim **shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement** (see §§725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) **has changed since the date upon which the order denying the prior claim became final.**¹³

The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, **the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based.** For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) **If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. . .**

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim. . . .[Emphasis added.]

20 C.F.R. § 725.309(d) (2003). Thus, it is necessary to look at the new evidence relating to each medical condition of entitlement upon which the denial was premised to determine whether it establishes that condition of entitlement.

The prior claim was denied because the medical evidence failed to establish the existence of pneumoconiosis, its causal relationship with coal mine employment, and total disability. Establishment of any of these elements would therefore reopen the claim for consideration of the merits. Thus, I must first determine whether the new evidence establishes that the Claimant suffers from pneumoconiosis.

¹³ For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in the section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) *Conditions of entitlement: miner*.

Existence of Pneumoconiosis

To prevail in a claim for Black Lung benefits, a claimant miner must establish that he or she suffers from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; that he or she is totally disabled, as defined in section 718.204; and that the total disability is due to pneumoconiosis. 20 C.F.R. §§718.202 to 718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). In *Director, OWCP v. Greenwich Collieries*, the Court invalidated the “true doubt” rule, which gave the benefit of the doubt to claimants. *See Id.* Thus, in order to prevail in a black lung case, a claimant must establish each element by a preponderance of the evidence.

Under 20 C.F.R. §718.202(a)(1)-(4), a finding of pneumoconiosis can be made based upon x-ray evidence, biopsy or autopsy evidence, presumption, or the reasoned medical opinion of a physician based on objective medical evidence. The United States Court of Appeals for the Sixth Circuit has often approved of the independent application of the subsections of section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis. *See Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc).

In the December 2000 amendments to the regulations, the definition of pneumoconiosis in section 718.201 has been amended to provide for “clinical” and “legal” pneumoconiosis and to acknowledge the latency and progressiveness of the disease. Clinical pneumoconiosis consists of those diseases recognized by the medical community as pneumoconioses, i.e. the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment (such as coal worker’s pneumoconiosis or silicosis). Legal pneumoconiosis is defined as “any chronic lung disease or impairment and its sequelae arising out of coal mine employment” and “includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.” 20 C.F.R. §718.201(a). The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. §718.201(b). Even if a physician states a claimant is not suffering from pneumoconiosis, the evidence must be examined in light of the broader legal definition of pneumoconiosis. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000).

X-Ray Evidence. Claimant has failed to establish pneumoconiosis by a preponderance of the x-ray evidence submitted in connection with this claim. The x-ray evidence is summarized above. Here, the record includes seven interpretations of four chest x-rays, five of which address the issue of whether the x-rays shows signs of pneumoconiosis; one of which only addressed the quality of the x-ray taken during the DOL examination; and the last of which was a hospital x-ray interpretation. Of the six interpretations, two were positive for pneumoconiosis and the remainder were negative or did not address the issue.

In determining the existence of pneumoconiosis based on chest x-ray evidence, “where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.” 20 C.F.R. §718.202(a) (1). The Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified Radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In the case of x-ray evidence, more recent positive evidence may be credited over older negative evidence, but the Benefits Review Board has stated that “it is irrational to credit the most recent evidence strictly on the basis of its chronology, if that evidence is negative for pneumoconiosis.” *Chaffin v. Peter Cave Coal Co.*, 22 B.L.R. 1-294, 1-302 (BRB 2003).

Applying these principles to the x-ray evidence before me, I find that it does not support a finding of coal worker’s pneumoconiosis:

1. There are two interpretations of record relating to the August 1, 1997 x-ray: a positive one by Dr. Baker (a B-reader) and a negative one by Dr. Halbert (a dually-qualified B-reader and board-certified radiologist). It is unclear whether Dr. Baker’s interpretation may be considered in evaluating the new evidence, as it was part of the record in the previous claim. Consideration of Dr. Halbert’s interpretation as “new” is also questionable, as his interpretation of this same x-ray was considered in the earlier claim. However, regardless of whether these interpretations are considered to be new, this x-ray may be deemed to be negative for pneumoconiosis in view of Dr. Halbert’s superior qualifications.¹⁴
2. There is only one interpretation of the July 29, 2002 x-ray, by hospital radiologist Dr. Singh. Dr. Singh found COPD and did not mention the existence of coal worker’s pneumoconiosis. As Dr. Singh did not interpret the x-ray under the ILO standards, his interpretation is not evidence of the presence or absence of pneumoconiosis under 20 C.F.R. §718.102(e).
3. There were two substantive interpretations of the October 20, 2002 x-ray taken during the course of the DOL examination: a positive interpretation by Dr. Baker, a B-reader and a negative interpretation by Dr. Halbert, a dually qualified reader. As the most qualified reader did not find pneumoconiosis, I find that the October 20, 2002 x-ray is negative for pneumoconiosis.
4. There was one interpretation of the November 5, 2002 x-ray, by Dr. Westerfield, a B-reader. As discussed above, although he noted granulomas, he found the x-

¹⁴ Of the x-ray interpretations of this x-ray submitted in connection with the previous claim, only Dr. Baker’s was positive. (DX 1).

ray to be negative for pneumoconiosis. As the single interpretation was negative, I find the November 5, 2002 x-ray was negative for pneumoconiosis.

Based upon the new x-ray evidence, Claimant failed to establish pneumoconiosis under §718.202(a)(1).

Autopsy or Biopsy Evidence. As there is no autopsy or biopsy evidence of record, Claimant has failed to establish the presence of the disease under 20 C.F.R. §718.202(a)(2).

Complicated Pneumoconiosis and Other Presumptions. A finding of opacities of a size that would qualify as “complicated pneumoconiosis” under 20 C.F.R. §718.304 results in an irrebuttable presumption of total disability. As there is no evidence of complicated pneumoconiosis, the section 718.304 presumption is inapplicable. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306 are also inapplicable, inter alia, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively. Further, section 718.306 does not apply, because the claim is not for death benefits. Thus, Claimant has failed to establish the presence of pneumoconiosis under 20 C.F.R. §718.202(a)(3).

Medical Opinions on Pneumoconiosis. The newly submitted medical opinions do not, by a preponderance of the evidence, establish pneumoconiosis. The following four physicians provided medical opinions addressing the issue of whether Claimant has pneumoconiosis: (1) Dr. Tammy Brown, Claimant’s treating physician (DX 14, 15; CX 1); (2) Dr. Glen Baker, the DOL examiner (DX 10, 33); (3) Dr. Byron T. Westerfield, Employer’s examining physician (DX 13, 16); and Dr. Bruce Broudy, Employer’s reviewing physician (EX 2). Their opinions are discussed in detail above. Essentially, Drs. Brown and Baker found that the Claimant suffered from both clinical and legal pneumoconiosis and Drs. Westerfield and Broudy found that he suffered from neither.

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians’ credentials. *See Millburn Colliery Co. v. Hicks*, 138 F.3d 524, 536 (4th Cir. 1998). A doctor’s opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). A “documented” opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and a “reasoned” opinion is one in which the underlying documentation is adequate to support the physician’s conclusions. *Fields, supra*. Special consideration may be given to the opinion of a treating physician under 20 C.F.R. § 718.104 based upon specified factors (the nature of the relationship, the duration of the relationship, the frequency of treatment, and the extent of treatment), but the opinion may only be given controlling weight if also credible in light of its reasoning and documentation, other relevant evidence, and the record as a whole. It is proper to discredit a medical opinion based on an inaccurate length of coal mine employment. *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993) (per curiam) (physicians reported an eight year coal mine employment history, but the ALJ only found four years of such employment).

Turning first to the issue of clinical pneumoconiosis, I find that Claimant has also failed to meet his burden on that issue. Dr. Brown, Claimant's treating physician, mentions "Black Lung disease" and silicosis, but she has failed to state a basis for those diagnoses apart from "history." The only chest x-ray findings that she mentioned related to emphysema and, as noted above, I have already found the x-ray evidence to not support finding of clinical pneumoconiosis. Dr. Baker's diagnosis of coal worker's pneumoconiosis was based upon his own interpretation of the chest x-ray (which was interpreted as negative by a more qualified reader) and a history of coal mine dust exposure. In contrast, Drs. Westerfield and Broudy found insufficient evidence to support a diagnosis of coal worker's pneumoconiosis, or clinical pneumoconiosis. I agree.

The issue of legal pneumoconiosis is more difficult, but I find that Claimant has failed to satisfy his burden. In this regard, all four of the physicians expressing opinions (Drs. Brown, Baker, Westerfield, and Broudy) agreed that the Claimant was suffering from COPD (or a combination of bronchitis and emphysema);¹⁵ however, only Drs. Brown and Baker found the coal mine dust exposure to be a contributory factor while Drs. Westerfield and Broudy attributed the COPD to cigarette smoking alone. The opinions are discussed in detail above and summarized below:

1. In an April 2003 response to a questionnaire, Dr. Brown noted that she had treated the Claimant from January 1998 through April 2003 for "Black Lung, symptoms of shortness of breath, cough, wheezing, and recurring bouts of acute bronchitis." She went on to state that he had chronic pulmonary disease related to his 18 years of employment in the coal mines. As the basis for her opinion, she referenced an abnormal chest x-ray revealing emphysematous lung and prolonged (18 year) exposure to coal dust.¹⁶ In her March 13, 2003 report, she somewhat cryptically stated: "His chest x-rays and pulmonary function tests are significant, and diagnostic of emphysema which by history has been related to silicosis."¹⁷ She has used a somewhat inflated coal mine employment history (as discussed above, I found 11 years of coal mine employment extending over a 16-year cumulative period, ending in 1984) and, while stating that exposure to coal dust was a major cause of Claimant's respiratory symptoms, she has failed to discuss the effect of Claimant's cigarette smoking history (which I have estimated as 45-pack-years, ending in 2002). An analysis of Dr. Brown's opinion reflects that it is based upon little more than respiratory symptoms coupled with a history of coal mine dust exposure.
2. Based upon the October 30, 2002 examination, Dr. Baker found three conditions that he found to be due to the combined effects of coal mine dust exposure and cigarette smoking – COPD, hypoxemia, and chronic bronchitis. In his initial report, he listed "PFTS", "PO₂," and "history of cough, sputum production and wheezing," respectively, as the bases for the diagnoses. Dr. Baker assumed 16 years of coal mine employment. He was given a 25-year smoking history of one half pack of cigarettes daily (which is less than the history of over 30-pack-years he gave to Dr. Baker in 1997 or the amount he admitted

¹⁵ Chronic Obstructive Pulmonary Disease (COPD) includes emphysema, bronchitis, and/or asthma. (See Dr. Westerfield's deposition transcript, DX 16, at 27).

¹⁶ It is not entirely clear what x-ray Dr. Brown was referencing in the April 12, 2003 questionnaire response or March 13, 2003 report, but in her initial (September 20, 2002) report she mentioned the finding of COPD based on the July 29, 2002 x-ray.

¹⁷ As discussed below, Dr. Cummings found "COPD with history of silicosis exposure" in a report submitted in connection with the previous claim.

to at the hearing). In his supplemental (August 2, 2004) report, Dr. Baker suggested that ten years was the cutoff for associating coal mine dust exposure with the listed diagnoses, and that if the Claimant had only nine years of such exposure, its effect would be “minimal” and “perhaps, not a significant contribution.” Dr. Baker did not explain the basis for his 10-year cutoff although it is worth noting that the 10-year period appears as a rebuttable presumption of a causal relationship (between coal mine employment and clinical pneumoconiosis) in the regulations.

3. In his November 5, 2002 examination report and at his April 18, 2003 deposition, Dr. Westerfield found the Claimant suffered from a moderate obstructive pulmonary impairment which he found to be entirely caused by Claimant’s cigarette smoking history (which he accurately estimated to be 30- to 50-pack years) and not at all by his coal mining (which he assumed to be 20 years underground, an overestimate.) Dr. Westerfield’s rationale is that cigarette smoking is the “number-one cause of chronic obstructive pulmonary disease” and he explained the mechanism by which it did so; he discounted coal mine dust because of the obstructive nature of the disorder and the period of time that elapsed before the symptoms arose. He noted that he Claimant had only recently given up smoking but he last worked in coal mining in 1985.
4. Dr. Broudy reviewed the medical evidence and prepared a report dated November 4, 2005, in which he stated that Claimant had a typical chronic obstructive airways disease due to cigarette smoking and there was no evidence that any lung impairment was related to coal mine dust. He explained that usually, when coal dust exposure caused impairment of this severity, it was a restrictive type of impairment and there was significant radiographic evidence of pneumoconiosis. Dr. Broudy apparently relied upon the smoking and coal mine employment histories recorded by Dr. Westerfield.

Thus, Dr. Brown and Dr. Baker have relied upon little more than symptomatology, test results, and coal dust exposure over a certain period of time, without explaining how they reached their conclusions based upon the symptomatology and test results (and, in the case of Dr. Brown, how cigarette smoking factored into her opinion), while Dr. Westerfield and Dr. Broudy have reached their conclusions based upon questionable generalizations as to the comparative effects of cigarette smoking and coal mine dust, which generalizations are unsupported, even if not hostile to the Act. Although the regulations (20 C.F.R. §718.104(d)) allow heightened weight to be given to the opinion of a treating physician, such as Dr. Brown, such a principle cannot allow controlling weight to be given to an opinion that is not reasoned and documented.

Notably, in amending the regulations in December 2000, the Department of Labor discussed the strong epidemiological evidence supporting an association between coal dust exposure and obstructive pulmonary disability (65 Fed. Reg. 79937-79945 (Dec. 20, 2000)), but it nevertheless chose to require that each individual claimant establish by a preponderance of the evidence that such an association occurred in that individual’s case. *Id.* at 79938. The difficulty of anyone satisfying this burden is made clear in the instant case. None of the opinions, in my view, adequately address the role that cigarette smoking and/or coal mine dust exposure played in this individual case. Dr. Brown did not address the possible effect of cigarette smoking; Dr. Baker assumed the two factors worked together, based upon an arbitrary cutoff of ten years of coal mine employment and an underestimated smoking history; and Drs. Westerfield and Broudy relied upon particular generalized assumptions without citing support for those assumptions. I

do not find any of these opinions to be persuasive. However, inasmuch as it is the Claimant's burden of proof, he is not assisted by the inadequacy of the analysis in the medical opinions. Accordingly, I find that Claimant has failed to establish legal pneumoconiosis based upon the medical opinion evidence.

Other Evidence of Pneumoconiosis. There is no other evidence on the issue of pneumoconiosis.

All Evidence on Pneumoconiosis. As this case arises in the Sixth Circuit, it would be sufficient if the new evidence established the presence of pneumoconiosis under any of the individual subsections of section 718.202(a); however, it fails to do so. Taking into consideration the new evidence on the issue of the existence of pneumoconiosis, I find that the Claimant cannot establish pneumoconiosis as defined by the regulations under the newly submitted evidence. Accordingly, this claim cannot be reopened based upon a finding of pneumoconiosis.

Causal Relationship

In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. 20 C.F.R. §718.203 (a). If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. §718.203(b). Although I have found that Claimant has established more than ten years of coal mine employment, I have also found that he has failed to establish pneumoconiosis based upon the newly submitted evidence. Thus, he is not entitled to the presumption under §718.203 nor has he directly shown a causal relationship between pneumoconiosis and coal mine employment based upon the newly submitted evidence.

Total Disability

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Where, as here, there is no evidence of complicated pneumoconiosis, total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment or comparable work. 20 C.F.R. §718.204(b)(2). For a living miner's claim, it may not be established solely by the miner's testimony or statements. 20 C.F.R. §718.204(d)(5).

According to his testimony and written submissions, Claimant last worked underground as a working foreman, a job that required him to fill in for absent employees and operate equipment. On a daily basis, he would have to lift up to 75 pounds alone, and every few months, he would have to lift 300 pounds with another miner, according to his testimony. He stated that he was required to lift 10 pounds in the employment description he provided in connection with his previous claim (DX 1) but in an updated form he described the lifting as varying from time to time from 10 to 200 pounds (DX 5). Claimant's job description must be considered in light of the medical evidence.

Based upon the newly submitted medical evidence and his testimony, I find that Claimant has established total disability under §718.204(b).

Pulmonary Function Tests As summarized above, pulmonary function tests were taken on September 19, 2002; October 30, 2002; and November 5, 2002. Only the September 19, 2002 results, taken at Dr. Brown's behest, are qualifying for total disability under the federal regulations, based upon qualifying FEV1, MVV, and FEV1/FVC ratio, both pre- and post-bronchodilator. The remaining two tests, which were taken slightly later, did not produce qualifying values, although the results were not entirely normal. Dr. Baker stated that the PFTs taken during his October 30, 2002 examination showed a "mild obstructive defect." During his November 5, 2002 examination of the Claimant, Dr. Westerfield obtained similar results to those of Dr. Baker and stated the following:

Spirometry demonstrates moderate obstructive ventilatory dysfunction.
There is no significant improvement following inhaled bronchodilator.

Accordingly, based upon the Part 718, Appendix B criteria, I find that the preponderance of the pulmonary function tests do not support a finding of total disability under §718.204(b)(2)(i).

Arterial blood gases. In addition, Claimant has failed to establish total disability through new arterial blood gas studies under §718.204(b)(2)(ii), based upon the September 19, 2002; October 30, 2002; and November 5, 2002 studies. None of the resting ABGs were qualifying. The resting results obtained during Dr. Brown's and Dr. Westerfield's examinations were essentially normal but Dr. Baker found "mild resting arterial hypoxemia." No exercise arterial blood gases were taken, however, so these results do not provide a basis for determining Claimant's ability to perform strenuous work.

Cor pulmonale with right-sided congestive heart failure. There is no evidence of cor pulmonale or congestive heart failure, so Claimant has not established total disability under section 718.204(b)(2)(iii).

Medical opinion evidence on total disability. Notwithstanding the nonqualifying testing, I find that the medical opinion evidence establishes total disability.

1. In this regard, Dr. Brown, the Claimant's treating physician, found him to be disabled based upon exertional dyspnea and cough. She went on to explain that the Claimant had recurrent bouts of bronchitis and pleuritic chest pain and that he had "observed dyspnea when in the office walking from the waiting room to the exam. room."

2. Dr. Baker found what he characterized as “Mild Impairment” but he nevertheless went on to opine that the Claimant lacked the respiratory capacity to perform the work of a coal miner or comparable work in a dust free environment. He based that conclusion on the FEV₁ (60 [% of expected]) and PO₂ (69 [as compared with the expected of “> 80”]).
3. Dr. Westerfield characterized the Claimant’s disability as an “AMA Class 2, 25% impairment” but he opined that Claimant had the respiratory capacity to perform the work of a coal miner or comparable work in a dust free environment. At his deposition, he explained that, while Claimant could return to coal mine employment “at a level of operating equipment” he “could not do arduous or heavy work.” (EX 15 at 23). Later, he explained that the Claimant could do “sedentary activities that would be mild to moderate work in terms of energy expenditure.” (EX 16 at 31).
4. Dr. Broudy opined that the Claimant had a lung impairment (obstructive airways disease) of moderate severity based upon the examinations of Drs. Westerfield and Baker. He noted that the study conducted under the direction of Dr. Brown showed somewhat lower (qualifying) results. When asked whether the medical records reflected that the Claimant was totally disabled as a result of pulmonary disease, he stated: “No it does not. As noted, two of the three spirometric studies exceed the minimum federal criteria for disability in coal workers.” He did not otherwise address the issue of Claimant’s capability to perform his last coal mine work.

At the hearing, Claimant stated that he was incapable of returning to his last coal mine employment based upon his breathing but he did so based upon his inability to inhale coal dust rather than his inability to perform the necessary work. (Tr. 35-36). He noted that he needed to lift 75 pounds, more or less, on a daily basis, depending on what happened, and that every three to five months he would have to assist in lifting a 300-pound battery. (Tr. 28). The coal was as low as 36 inches, requiring him to walk, squat or crawl as necessary. (Tr. 28).

In evaluating these opinions, I find that they are in substantial agreement, that the Claimant is impaired from performing heavy work but he is capable of performing sedentary work. Thus, Dr. Westerfield concluded that the Claimant was not disabled from performing his last coal mine job because he considered it to involve merely operating equipment and being sedentary in nature, but he opined that Claimant could not perform arduous or heavy work. Dr. Baker found only mild impairment but he went on to opine that the Claimant could not perform his last coal mine work due to his reduced FEV₁ (obstruction) and reduced PO₂ (oxygenation). The latter finding was not replicated in the other ABGs but all of the PFTs showed obstruction. As noted, treating physician Dr. Brown found him to be totally disabled. In addition to the qualifying spirometry (in contrast to the spirometry performed by Drs. Baker and Westerfield), she based her opinion in part on her own observations of the difficulties that Claimant had walking around her office. She did not, however, discuss the requirements of the Claimant’s last coal mine job. Dr. Broudy noted that two of the three pulmonary function tests were nonqualifying but he did not squarely address the issue of Claimant’s capability to return to his coal mine employment. Taken together, I find that these opinions establish Claimant’s total respiratory disability when it is taken into consideration that his job, as described by himself at the hearing and in written submissions, was not sedentary or nonstrenuous in nature, as he was required to fill in for absent employees in a variety of jobs and, even when employed as an equipment operator, was frequently required to lift 75 pounds and sometimes more.

Claimant has therefore satisfied his burden of proving total disability through medical opinion evidence under section 718.204(b)(2)(iv).

Section 718.204(b)(2) as a whole. Looking at §718.204(b)(2) as a whole, based solely upon the newly submitted evidence, I find that Claimant has established total disability based upon the medical opinions considered along with his testimony and the other evidence of record. Quite simply, he has shown that he lacks the respiratory or pulmonary capacity to perform the strenuous work required in his last and usual coal mine employment. Thus, he has established one of the conditions of entitlement upon which the previous claim was denied. I must therefore proceed to consideration of the claim on its merits.

Merits of the Claim

Considering the new evidence discussed above in the context of the evidence previously of record, I find that the Claimant cannot prevail based upon all of the evidence of record because he cannot establish that he suffers from pneumoconiosis. As noted above, the newly submitted evidence fails to establish pneumoconiosis. Further, the medical evidence previously of record also falls short. Specifically, it fails to establish the existence of pneumoconiosis (or causal relationship) under any of the methods set forth in section 718.202(a) because:

1. Out of 15 x-ray interpretations (10 for the August 1, 1997 x-ray, one for an October 6, 1997 x-ray, one for an August 18, 1998 x-ray, and three for a January 26, 1999 x-ray), only one (Dr. Baker's interpretation of the August 1, 1997 x-ray) was positive for pneumoconiosis; however, that x-ray was read as negative by nine other readers, some of whom were dually qualified as B-readers and board-certified radiologists, whose readings outweigh that of Dr. Baker. The x-rays do not support a finding of pneumoconiosis.
2. There was no biopsy previously of record.
3. There was no evidence of complicated pneumoconiosis or a basis for invoking any of the other presumptions.
4. Of the physicians expressing opinions in connection with the previous claim (Drs. Baker, Westerfield, Broudy, and Cummings) only Dr. Baker found the Claimant to suffer from clinical pneumoconiosis (which he found based upon his own x-ray interpretation and sufficient duration of exposure) or legal pneumoconiosis (which he listed as chronic bronchitis and COPD due to the combined effects of coal dust exposure and cigarette smoking); however, his opinion was conclusory in nature and is not a reasoned, documented opinion upon which a finding of pneumoconiosis may be predicated. Dr. Cummings had an impression of "COPD with history of silicosis exposure [apparently a reference to silica exposure]" and "Chest pain" but such findings are not tantamount to a finding of legal pneumoconiosis. His opinion is not a reasoned, documented opinion either. Drs. Broudy and Westerfield found no evidence of either clinical or legal pneumoconiosis so their opinions do not support a finding of pneumoconiosis. Taken as a whole, the medical opinions previously of record do not establish pneumoconiosis.

In view of the above, considering the new evidence along with the evidence previously of record, I find that Claimant has failed to establish that he suffers from either clinical or legal pneumoconiosis based upon any of the available methods under the regulations.

CONCLUSION

Inasmuch as the Claimant has established total disability based upon the newly submitted evidence, the requirements of 20 C.F.R. §725.309 have been satisfied and this claim is reopened for adjudication of the merits. However, when this claim is considered on the merits, it fails because the existence of pneumoconiosis, an essential element of a claim for black lung benefits, cannot be established based upon the record as a whole. Thus, the claim must be denied and a separate discussion and analysis of the remaining issues raised in this claim is unnecessary.

ORDER

IT IS HEREBY ORDERED that the claim of Claimant S. G. for black lung benefits be, and hereby is, **DENIED**.

A
PAMELA LAKES WOOD
Administrative Law Judge

Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207.

Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen H. Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).